

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

08258		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08251	
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM H ASTLE			2a. DATE OF DEATH Month Day Year JUNE 3 1969		2b. HOUR 8 P. M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 3/21/82		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CECIL		
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DELAWARE	13b. COUNTY NEWCASTLE	13c. CITY OR TOWN NEWARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 20 E. CLEVELAND AVE	
14. FATHER'S NAME First Middle Last WILLIAM ASTLE	15. MOTHER'S MAIDEN NAME First Middle Last REBECCA LOUISA HARRIGAN		Address ELKTON MD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)	16b. SOCIAL SECURITY NO. 221-07-5983A	17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHO SARCOMA NECK 2001 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION JAN 14, 69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LYMPHO-SARCOMA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1966, to June 8, 1969, that (I) (we) last saw the deceased alive on June 7, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. Davis		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		22e. ADDRESS CHESAPEAKE CITY MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 12, 1969	23c. NAME OF CEMETERY OR CREMATORY Calvert Friends		23d. LOCATION (City or Town) (County) (State) Calvert, Maryland	
24. FUNERAL DIRECTOR K. T. Jones		ADDRESS Newark, Del		25a. REC'D BY REGISTRAR JUN 24 1969	25b. REGISTRAR'S SIGNATURE Charles Jones

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08259

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08252

1. DECEASED-NAME (Type or print) BLENDY		First STEPHEN Middle	Lost	2a. DATE OF DEATH Month 18 Day 69 Year		2b. HOUR 8:59 AM
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH 12-18-87		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) AUSTRIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL		
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY CECIL	13c. CITY OR TOWN CHESAPEAKE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last NO INFO.			15. MOTHER'S MAIDEN NAME First Middle Last NO INFO.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 216-18-6235		17. INFORMANT Address MRS. TERLA BLENDY CHESAPEAKE CITY MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 4123 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ARTERIO-SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) BLINDNESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 HOURS Nearly 4 YEARS
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from JUNE 17, 1969 , to JUNE 18, 1969 , that (I) (we) last saw the deceased alive on JUNE 18, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. FARREN W. OBENSHAW						
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/18/69
22d. PHYSICIAN'S NAME (Type) HENRY VIDAUERS MD		22e. ADDRESS CHESAPEAKE CITY MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-20-69		23c. NAME OF CEMETERY OR CREMATORY ST. ROSE OF LIMA		23d. LOCATION (City or Town) (County) (State) CHESAPEAKE CITY CECIL MD
24. FUNERAL DIRECTOR R.T. FEARD FUNERAL HOME		ADDRESS CHESAPEAKE CITY MD		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE [Signature]

08333

STATE OF TEXAS

08333

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are faintly visible.]

[Vertical text on the right margin, likely bleed-through from the reverse side. Some words like "NOTARY PUBLIC" and "COMMISSION EXPIRES" are faintly visible.]

CERTIFICATE OF DEATH

08260

08253

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Lydia Maxwell Cameron			2a. DATE OF DEATH June 18 1969			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 25, 1880		6. AGE (In years last birthday) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Cecil Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Main Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER E. Main Street	
14. FATHER'S NAME James Maxwell			15. MOTHER'S MAIDEN NAME Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Mary Mahoney		Address Rising Sun, Md. R.D.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4/24 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) Dis. 30 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1966 to 1969, that (I) (we) lost saw the deceased alive on June 17 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Ernest W. Seiter M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 19, 1969	
22d. PHYSICIAN'S NAME (Type) Ernest W. Seiter M.D.				22e. ADDRESS Rising Sun, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 21, 1969		23c. NAME OF CEMETERY OR CREMATORY West Nottingham		23d. LOCATION (City or Town) (County) (State) Colora Cecil Md.			
24. FUNERAL DIRECTOR Ernest E. Mullen				ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
45M - 1/69

08261		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08254	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last Edward NMN CHICHESTER				Month Day Year June 2, 1969		4:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		Negro		July 24, 1896		72 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Virginia		U.S.A.				Cecil Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point		V A HOSPITAL		Janitor		Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Virginia		Warrenton				44 Fourth Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last James Chichester		First Middle Last Grace Black					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		WW I 224-16-6482		VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach w/liver metastasis 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) VA		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from May 7, 1969, to June 2, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. SIGNATURE Irina Reus				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) IRINA REUS, M.D.				22e. ADDRESS VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
June 5, 1969		June 5, 1969		Warrenton Cemetery		Warrenton, Oregon, VA	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
G. W. ...		Warrenton, Va.		JUN 9 1969		...	

08381

UNITED STATES DEPARTMENT OF JUSTICE

08381

THOMAS HARRIS, A.D.
and, Harry Taylor, Jr.

On the 1st day of June, 1938, at the County of ... State of ...
I, the undersigned, a Notary Public in and for the State of ...
do hereby certify that the foregoing is a true and correct copy of the ...
as the same appears from the records of my office.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last Thomas R COMBS					Month Day Year June 18 1969				
2b. HOUR 8:23 AM									
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11 24 29		6. AGE (In years last birthday) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian-GSA		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8031 1/2 Edgewater Avenue	
14. FATHER'S NAME First Middle Last JIM COMBS (D)		15. MOTHER'S MAIDEN NAME First Middle Last ROSA MONEY (L)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 1948-1951		16c. SOCIAL SECURITY NO. 240403525		17. INFORMANT VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia of left lung w/massive pleural effusion</u>									
295.2 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immobilization associated w/stuporous</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>schizophrenic, catatonia</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 2</u> , 19 <u>69</u> , to <u>June 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. L. Mooney, M.D.					22c. DATE SIGNED 6-18-69				
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.					22e. ADDRESS VAH, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-21-69		23c. NAME OF CEMETERY OR CREMATORY Cecil of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Craigh Funeral Home, Baltimore, Md. 121 Chesapeake Ave		25a. REC'D BY REGISTRAR DATE JUN 20 1969		25b. REGISTRAR'S SIGNATURE P. J. Judge					

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08263		CERTIFICATE OF DEATH						08256			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
John			COWAN			Month Day Year June 24 1969			12:01 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		12-10-25		43 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Tenn.		U.S.A.				Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point			VA Hospital			Carpenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Virginia					Alexandria				332 N. Columbia St.,		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
John R. Cowan (Dec)			Annie Turner (Deceased)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
Yes			WW II		224-36-76-03			VA Hospital Records - Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral severe</u>											
1621 DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of right lung with metastases to liver.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION				Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-30-69</u> , 19 <u> </u> , to <u>6-24-69</u> , 19 <u> </u> , that (I) (we) (we) (the deceased) died on <u>6-24-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
<u>A. L. Mooney, M.D.</u>								<u>6-24-69</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
A. L. Mooney, M.D.						VA Hospital - Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		June 27, 1969		Culpeper National		Culpeper, Virginia					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Cunningham, Robert</u>						JUN 30 1969		<u>O'Connell, Judge</u>			

88280

STATE OF TEXAS

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of ... State of Texas.
Witness my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 19...
Clerk of the County of ... State of Texas

Notary Public in and for the State of Texas
My Commission Expires ...

0-3-0 00-03-

0-3-0 00-03-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08264		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08257	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year
PHYLLIS RUTH CRAWFORD					JUNE 30, 1969
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	2b. HOUR
FEMALE	WHITE	AUGUST 5, 1891		77 YRS.	8:30 PM
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
PENNA.	USA	CECIL			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
LOCUST POINT	RD # 2	HOUSEWIFE	AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
MD	CECIL	LOCUST PT.	RD # 2		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
EDGAR			RUTH	EMMA SAUERMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT		Address	
No		MRS. LOIS C. MANN		LOCUST PT. MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC HYPERTENSIVE CV. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) SEVERAL YEARS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from October 10, 1967, to JUNE 2, 1969, that (I) (we) last saw the deceased alive on JUNE 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
[Signature]		JULY 1 - 1969		[Signature]	
22e. ADDRESS		22f. ADDRESS			
[Signature]		CHESAPEAKE CITY MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	7/2/69	DOYLESTOWN CEM.	DOYLESTOWN	PENNA.	
24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
PIPPIN FUNERAL HOME	JUL 3 1969		[Signature]		

08280

STATE OF TEXAS

08280

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the ... as the same appears from the records of said County.

Witness my hand and the seal of said County, at the City of ... this ... day of ... 19...

Clerk of the County of ... State of Texas



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

08265										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08258																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
First Middle Last										Month Day Year										P: 15 PM																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS																													
Male										White										Jan 24 1913										56 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Elkton										Union Hospital										Track Foreman										Railroad																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																																							
Md.										Cecil										North East										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										R.D. #2																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																																																	
Glenn G. Edwards Sr.										Melissa Poe																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
No										705-09-7345										Irene R. Edwards										North East, Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I. DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a)										Lower respiratory hemorrhage																																																																					
1621										DUE TO, OR AS A CONSEQUENCE OF																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Bronchogenic carcinoma																																																																					
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (1) (this hospital) attended the deceased from 6-29, 1963, to 6-5, 1969, that (1) (we) last saw the deceased alive on 4-15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
Jay S. Barnhart Jr. M.D.										6-5-69																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Jay S. Barnhart Jr.										4 Muldin Ave, North East, Md.																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Borke										June 9, 1969										North East Meth.										North East Cecil Md.																																																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Paul A. Crandall										JUN 9 1969										Charles Judge																																																											
Grant Funeral Home										North East, Md.																																																																					

08282

STATE OF NEW YORK

08282

IN SENATE
January 1, 1903

1

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 1, 1903

ALBANY:
JANUARY 1, 1903

13719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08266

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08259

1. DECEASED-NAME (Type or print) First <i>John</i> Middle <i>Russell</i> Last <i>Foley</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>2</i> Year <i>1969</i>			2b. HOUR <i>4:00 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>Cau</i>		5. DATE OF BIRTH <i>Dec. 7, 1896</i>		6. AGE (In years last birthday) <i>72</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cecil</i> Md.	
10. CITY OR TOWN OF DEATH <i>Perryville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>R.F.D.#1</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>W.H. Perry Pot</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Perryville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>R.F.D.#1</i>		14. FATHER'S NAME First <i>John</i> Middle <i>Foley</i> Last <i>Price</i>		15. MOTHER'S MAIDEN NAME First <i>Florence</i> Middle <i>Price</i> Last <i>Price</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>220-40-8414</i>		17. INFORMANT <i>Laura E. Foley, Perryville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF <i>& Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pulmonary tuberculosis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/1</i> , 19 <i>68</i> , to <i>6/2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6/2</i> , 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward C. Loo</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/2/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo</i>		22e. ADDRESS <i>211 N. Union Ave., Havre de Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-5-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Marks Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Perryville, Cecil, Md.</i>	
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>		ADDRESS		25a. REGD. BY REGISTRAR <i>JUN 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

05280

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

05280



TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

4409

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08267					08260						
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Mary		E.		Gehr				6 Month 7 Day 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
Female		Cau.		Oct. 9, 1879		89 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Pa.		USA				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Elkton		Devine haven nursing Home		Retired		Clerk					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Cecil		Charlestown							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Henry		H.		Harnish				Alice		Elliott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				202-16-8373		Grace H. Smith, Charlestown, Maryland.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4409										Generalized arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF										Unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April 7, 1969, to June 7, 1969, that (I) (we) last saw the deceased alive on June 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 9:30 P.M.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
S. Ralph Andrews, Jr. M.D.		June 7, 1969		S. RALPH ANDREWS, JR. M.D.		223 E MAIN ST., ELKTON, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		June 10, 1969		Grace Evangelical Ch. Cem. Millersville		Pa.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lee A. Patterson		Perryville, Md.		JUN 11 1969		[Signature]					

101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

08268		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08261	
1. DECEASED-NAME (Type or print) First Middle Last HARRY F. GORRELL				2a. DATE OF DEATH Month Day Year 6 24 1969			2b. HOUR 10:27 PM
3. SEX male	4. RACE white		5. DATE OF BIRTH Sept. 3 1905 9-3-06		6. AGE (In years last birthday) 63	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sgt. of Guard		12b. KIND OF BUSINESS OR INDUSTRY Chemical	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Joseph H. Gorrell		15. MOTHER'S MAIDEN NAME First Middle Last Clara I. Rea		13e. STREET AND NUMBER R.D. # 2			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 212-01-7538		17. INFORMANT Mrs. Beulah E. Gorrell		Address R.D. 2 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate extension to brain</u> 1 mo 185x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate gland</u> 8 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Nephritis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-22, 1969</u> , to <u>6-24, 1969</u> , that (I) (we) last saw the deceased alive on <u>6-24, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (<u>did</u>) (did not) view the body after death.							
22b. SIGNATURE <u>Williford Eppes</u> MD				22c. DATE SIGNED 6-25-69		22d. PHYSICIAN'S NAME (Type) Williford Eppes	
22e. ADDRESS Union Hospital, Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 28, 1969		23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.	
24. FUNERAL DIRECTOR <u>Paul R. Crouch</u> Grant Funeral Home		ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR DATE JUN 27 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08269 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7a, Film 444 7/8/69

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08262

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
LEON		J.		GROSKY				6-30-1969		1139		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	Nov. 18, 1915		53 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year		1969 1200 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Pennsylvania		U.S.A.				Cecil						Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
North East		Yacht Club, North East		Auditor General		State Govt.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Pennsylvania		Lebanon		Lebanon				1254 Willow Street					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle Last	
Max		Grosky		Blanche		Katz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				Rohland Funeral Home, Lebanon, Pa.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>												Years	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
<u>Diabetes Mellitus</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <u>Tillman J. Johnson</u>				M.D.				22b. DATE SIGNED <u>6-30-69</u>					
EXAMINER'S NAME (Type) <u>Tillman J. Johnson</u>				M.D.				ADDRESS (Street, city, town, or county) <u>Elkton, Cecil</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		7/1/69		Beth Israel Cemetery		Lebanon, North Lebanon Co.							
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>						ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08270

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08263

1. DECEASED-NAME (Type or print) PHYLLIS ELIZABETH HINKLE			2a. DATE OF DEATH Month June Day 19 Year 1969			2b. HOUR 5 P. M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 14, 1909		6. AGE (In years lost birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL Md.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY CECIL		13c. CITY OR TOWN NORTHEAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 20 BEACH ST	
14. FATHER'S NAME First ROBERT Middle MORROW Last MORROW			15. MOTHER'S MAIDEN NAME First ALMIRO Middle ALMIRO Last NO INFO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, none or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 185-032320		17. INFORMANT Address WM. G. HINKLE NORTHEAST, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c) Gall bladder stone Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 2-10 , 19 69 , to 6-19 , 19 69 , that (1) (we) last saw the deceased alive on 6-19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. S. Barnhart Jr				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-20-69	
22d. PHYSICIAN'S NAME (Type) W. S. BARNHART JR				22e. ADDRESS 3 MAULDIN AVE NORTHEAST, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JUNE 24, 1969		23c. NAME OF CEMETERY OR CREMATORY ROMANS VILLE CEM.		23d. LOCATION (City or Town) (County) (State) CHESTER Co. PENNA			
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		ADDRESS ELKTON, Md		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

08271

CERTIFICATE OF DEATH

08264

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Elkton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS R.D. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NICHOLAS First HUBIS Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 16, 1886 9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days Hours Min. 25 1969				4. DATE OF DEATH Month 6 Day 25 Year 1969			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farming 11. BIRTHPLACE (County & State, or foreign country) Austria 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Steven Hubis 14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mrs. Mary Hubis, Elkton, Md. 21921				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 410.9 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary arteriosclerosis DUE TO (c) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CVA in 1966, BPH, chronic urinary tract obstruction.						INTERVAL BETWEEN ONSET AND DEATH? 15 min. 3 years? 10 years?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/16 , 19 58 , to 6/25 , 19 69 , that (I) (we) saw the deceased alive on 6/16 , 19 69 , and that death occurred at 10:30 AM, from causes and on the date stated above.							
22a. SIGNATURE P. STAVRAKIS M.D.				22b. DATE SIGNED 6/25/69		22c. PHYSICIAN'S NAME (Type) P. STAVRAKIS M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/69		23c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery		23d. LOCATION (City or Town) (County) (State) Fair Hill, Md.	
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.				25a. REC'D BY REGISTRAR DATE JUL 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
Hershel		Lee		Kennedy		June		25, 1969		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male		White		July 13, 1904		64 yrs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
North Carolina		U.S.A.				Cecil				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Elkton		Union Hospital		Gas lineman		Elkton Gas Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER (mailing address)		
Maryland		Cecil		Calvert				R.D. Nottingham, Pa.		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Arthur		Kennedy						Betty		Sexton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No				Mrs. Alice Kennedy		R.D. Box 175 Nottingham, Pa.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>										
188X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>ADENOCARCINOMA BLADDER</u>										3 YEARS.
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
<u>Pyelonephritis, Hydronephrosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>69</u> , to <u>Present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>24 June</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<u>Robert L. Gray M.D.</u>		26 June 1969		Robert L. Gray		123 W. High St. Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/28/69		Roaring River Church Cemetery, Roaring River, N.C.		Wilkes,				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
<u>W. E. Hicks</u>		JUL 2 1969		<u>W. Charles Judge</u>						
Hicks Home for Funerals, Elkton, Md.										

MEDICAL CERTIFICATION

08273

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June 2, 1960

Memorandum

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July 13, 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

08273

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08266

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
RIENZI		B.		LEMUS	Month 6 Day 6 Year 69		5:05 PM			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR			
Male	Negro		1-8-80		89 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		USA				Cecil Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point		Veterans Administration								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Virginia				Richmond				2070 Thorpe St.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Charles		H.		Lemus	Sophia				Walker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
Yes		S A W		721-03-2582		VA Hospital, Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural effusion, massive right lung.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary congestion and edema bilateral.</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease with myocardial fibrosis severe</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> , 19 <u>69</u> to <u>June 6</u> , 19 <u>69</u> xxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A. L. Mooney, M.D.</u>					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6-6-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>A. L. Mooney, M.D.</u>					22e. ADDRESS <u>VAH, Perry Point, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6/13/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City or Town) <u>Baltimore</u> (County) (State)				
24. FUNERAL DIRECTOR <u>Cunningham & Son</u>		ADDRESS <u>Harvard Ave, Md</u>		25a. REC'D BY REGISTRAR <u>JUN 11 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

5588

WILEY • JOURNAL OF CLIMATE

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Reviews

2. The second part of the paper is devoted to the study of the asymptotic behavior of the solutions of the system (1) as $\epsilon \rightarrow 0$. It is shown that the solutions of the system (1) converge to the solutions of the system (2) as $\epsilon \rightarrow 0$.

• 1950 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4369

2 1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Lost			2a. DATE OF DEATH Month Day Year			2b. HOUR
Cora			M. MacKenzie			June 26, 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		March 12, 1890			79 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Cecil Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Elkton			Union Hospital			Housewife			---
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Lost			First Middle Lost						
William Sprout			Sarah McCullough						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No					Mr. William MacKenzie, Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>436.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro-Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>7 wks.</u> <u>1 1/2 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> , 19 <u>67</u> , to <u>6-26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rolando A. Najera</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/30/69</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Rolando A. Najera					105 E. Main St., Elkton, Md. 21921				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		6-30-69		Cherry Hill Meth. Cemetery			Cherry Hill, Cecil, Md.		
24. FUNERAL DIRECTOR <u>Hicks Home for Funerals</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

08234

08234

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, DISTRICT OF COLUMBIA

DATE OF DEATH

1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

08275		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		08268	
1. DECEASED-NAME (Type or print)		First Victoria		Middle G.		Last Mackey	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 1, 1894		20. DATE OF DEATH Month June Day 10, Year 1969	
70. BIRTHPLACE (State or foreign) Elkton, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
130. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Elwood Middle Janney		15. MOTHER'S MAIDEN NAME First Margaret Middle Mc Cauley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO.	
17. INFORMANT H. Kenneth Mackey, RD 4 Box 22, Elkton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min Years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 9 P.M. 6-10-1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 6-10-1969, that (I) (we) lost saw the deceased alive on 6-10-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.	
22b. SIGNATURE Williford Eppes MD		22c. DATE SIGNED June 11, 1969		22d. PHYSICIAN'S NAME (Type) Williford Eppes, M. D.		22e. ADDRESS 327 E. Main St., Newark, Delaware	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.		23d. LOCATION (City or Town) (County) (State) Cherry Hill Cecil Md.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Elkton	

08573

DEPARTMENT OF HEALTH

08573



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08276				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08269			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR P			
Dora McCabe				Month 6 Day 24 Year 1969				1:30 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		4/15/95		74 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Chester, Pa.		U.S.A.				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Elkton		Union Hospital Cecil Co. Domestic									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Cecil		Elkton				116 Clinton Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.		17. INFORMANT		Address			
George McCabe		Cora		215-22-6795		Frank McCabe		116 Clinton St., Elkton			
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident								9- Days			
4123 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease								3- Years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes								2-Months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.O. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6/11/69, to 6/21/69, that (I) (we) lost the deceased alive on 6/21/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
James L. Johnson M.D.						6/21/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
James L. Johnson M.D.		245 E. High St., Elkton Cecil Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/25/69		Providence Cem.		Elkton, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Chuck Bell		909 Poplar St.		JUN 27 1969		Charles Judge					

08316

STATE OF NEW YORK

08316



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain the original pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08277

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08270

1. DECEASED-NAME (Type or print) LUCAS ALPHONSE MICHAEL			2a. DATE OF DEATH Month JUNE Day 13 Year 1969			2b. HOUR 11:53 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 14, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL Md.					
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pharmacist			12b. KIND OF BUSINESS OR INDUSTRY Drug Sales		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5215 Anthony Avenue		
14. FATHER'S NAME First Alphonse Middle Michael Last Michael			15. MOTHER'S MAIDEN NAME First Ewudokia Middle Unknown Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service) WW II			16b. SOCIAL SECURITY NO. 21712 8892		17. INFORMANT Address VA Hospital Records, Perry Point, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4123 DUE TO, OR AS A CONSEQUENCE OF Severe Arteriosclerotic Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Many years DUE TO, OR AS A CONSEQUENCE OF (c) Many years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) VA		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (the hospital) attended the deceased from Jan. 4 , 19 68 , to June 13 , 19 69 XXXXXX/XXXXXX from the deceased came on XXXXXXXXXXXXXXXXXXXX , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) did XXXXXX view the body after death.											
22b. SIGNATURE R. E. MORRIS, M.D.						DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-14-69	
22d. PHYSICIAN'S NAME (Type) R. E. MORRIS, M.D.						22e. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/17/69.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE JUN 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

7526

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08278

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08271

1. DECEASED-NAME (Type or Print) PAUL GEORGE MONTGOMERY			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> June 29, 1969			2b. HOUR 3:30		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-28-36	6. AGE (In years last birthday) 32 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month June Day 29 , Year 1969		
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) M. E. Yohn Co.		12b. KIND OF BUSINESS OR INDUSTRY oil	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa. COUNTY Montgomery		13b. CITY OR TOWN Pottstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 181 N. Franklin Street		
14. FATHER'S NAME First George Middle R. Last Montgomery			15. MOTHER'S MAIDEN NAME First Ann U. Middle Swetzer Last Swetzer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 198-26-2508		17. INFORMANT 181 N. Franklin St., Katherine J. Montgomery, Pottstown, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Drowning IMMEDIATE CAUSE (a) 910.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 3:00 P.M. 6-29-1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drowning				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water		21f. LOCATION Street or R.F.D. No. Murphy Beach		City or Town Charlestown		County Cecil
21f. LOCATION State M.D.		22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Ronald N. Kornblum		EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 6/30/69		
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 7-3-69		23c. NAME OF CEMETERY OR CREMATORY West End Cemetery		23d. LOCATION (City or Town) (County) (State) Pottstown, Montgomery, Pa.		
24. FUNERAL DIRECTOR Ralph E. Hicks				ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE R. C. ...

54

03-11-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5749

1

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Thelma</i>			First <i>E.</i> Middle <i>Murphy</i> Last			2a. DATE OF DEATH <i>June</i> Month <i>6</i> Day <i>1969</i>		2b. HOUR M		
3. SEX <i>Female</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH <i>July 5, 1903</i>		6. AGE (In years last birthday) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cecil</i>				
10. CITY OR TOWN OF DEATH <i>Elkton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Union Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>rest.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Charlestown, Md.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME <i>Wilburforce</i>			First <i>Marshall</i> Middle Last			15. MOTHER'S MAIDEN NAME <i>Clara</i>			First <i>Harrison</i> Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>151-01-5281</i>		17. INFORMANT <i>Ralph H. Murphy, Charlestown, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepato-renal failure</i> <i>5749</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute toxic hepatic necrosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Halothane anesthetic.</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>Arteriosclerotic cardiovascular disease</i>										
19a. DATE OF OPERATION <i>5-22-69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>5-22, 1969</i> , to <i>6-6, 1969</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>6-6, 1969</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) (did not) view the body after death.										
22b. SIGNATURE <i>Jay S. Barnhart, Jr., M.D.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-7-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Jay S. Barnhart, Jr., M.D.</i>		22e. ADDRESS <i>North east, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 8, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Charlestown Cemetery</i>		23d. LOCATION (City or Town) <i>Charlestown</i>		(County) <i>Cecil, Md.</i> (State)		
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Sons, Perryville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>June 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Robert S. [Signature]</i>				

0526

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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08280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08273

1. DECEASED-NAME (Type or Print) EUGENE D. REGAN						2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year June 7, 69			2b. HOUR 10:15 P		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-18-24		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) Phila. Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Chesapeake City				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Behind Manor Inn Tavern Rte. 213-Chesapeake City, M.D.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Finance		12b. KIND OF BUSINESS OR INDUSTRY Mfg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Delaware				13b. COUNTY New Castle				13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 600 Canbridge Drive											
14. FATHER'S NAME First Jeremiah Middle Regan Last Regan						15. MOTHER'S MAIDEN NAME First Rose Middle Rose Last Rose					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO. WW 2 207-12-4743		17. INFORMANT Margaret M. Regan				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest during a convulsive attack (Epilepsy) DUE TO, OR AS A CONSEQUENCE OF attack (Epilepsy) (b) attack (Epilepsy) DUE TO, OR AS A CONSEQUENCE OF attack (Epilepsy) (c) attack (Epilepsy)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. 19 P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher				EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 6-10-69		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery				23d. LOCATION (City or Town) (County) (State) Wilmington New Castle, Del.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.				25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

0320

18280 MEDICAL EXAMINER CERTIFICATE OF DEATH

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08281					08274					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last					Month Day Year					
Hazel ADELE Reynolds					JUNE 5, 1969					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
FEMALE		WHITE		AUG. 28, 1911		37		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
VIRGINIA		USA				CECIL				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
CALVERT			CALVERT MANOR N.H.			HOUSEWIFE			AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
MD			CECIL CHES. CITY			RD #1				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
WILLIAM F MURPHY			NORA B CROCKETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			216-20-1266			RUTH CONNELL CITY, MD			years	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident										
4369 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Advanced senility Paralysis of speech and right side.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 68, 19, to June 69, 19, that (I) (we) last saw the deceased alive on June 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Wallace Obenshain					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6 June 1969			
22d. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.					22e. ADDRESS Cecilton, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
CREMATION		6/9/69		SILVER BROOK		WILMINGTON, DE.				
24. FUNERAL DIRECTOR PIPPINI FUNERAL HOME					ADDRESS ELKTON, MD		25a. RECEIVED BY REGISTER JUN 9 1969			
							25b. REGISTRAR'S SIGNATURE			

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08281

GENERAL INQUIRY

08281

General

General

General

General

General

General

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

08282		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08275	
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH		2b. HOUR
First Middle Last Herbert W. Scruggs			Month Day Year June 10, 1969		5:45A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
Male	White	January 2, 1903		66 YRS.	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH		
Tennessee	U.S.A.		Cecil		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital		Machinist		Chrysler Corp
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Cecil	Elkton		P.O. Box 852	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
George Scruggs		Emma Ogg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
No	246-09-7234	Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> <u>under a tree</u> <u>sev. yrs.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>68</u> , to <u>June 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Rolando A. Najera</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/10/69</u>	
22d. PHYSICIAN'S NAME (Type) Rolando A. Najera		22e. ADDRESS 105 E. Main St. Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/14/69	23c. NAME OF CEMETERY OR CREMATORY Black Cemetery		23d. LOCATION (City or Town) (County) (State) Clinton, Tennessee	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR JUN 18 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08222

08222

CERTIFICATE OF DEATH

Reported on June 10, 1968

Name: [illegible]
 Sex: [illegible]
 Race: [illegible]
 Date of Birth: [illegible]
 Place of Birth: [illegible]
 Usual Residence: [illegible]
 Usual Occupation: [illegible]
 Usual Employer: [illegible]
 Usual Address: [illegible]
 Usual Telephone: [illegible]

Hospital Record: [illegible]
 Date of Death: [illegible]
 Cause of Death: [illegible]
 Manner of Death: [illegible]

Date of Report: [illegible]
 Signature: [illegible]
 Title: [illegible]

Death Certificate No. [illegible]
 Date of Death: [illegible]
 Cause of Death: [illegible]
 Manner of Death: [illegible]

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08283

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08276

1. DECEASED-NAME (Type or Print) <u>HARRY</u> <u>L.</u> <u>SIMON</u>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>6</u> Day <u>11</u> Year <u>1969</u>				2b. HOUR <u>4:30</u> P.M.	
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>6/17/1898</u>	6. AGE (in years last birthday) <u>70</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>11</u>	IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>	2c. DATE PRONOUNCED DEAD Month <u>6</u> Day <u>11</u> Year <u>1969</u>			2d. HOUR <u>4:30</u> P.M.
7a. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>CECIL</u> Md.			
10. CITY OR TOWN OF DEATH <u>ELKTON</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>UNION HOSPITAL</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Secretary</u>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>			13b. COUNTY <u>CECIL</u>		13c. CITY OR TOWN <u>CHESAPEAKE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>HOLLYWOOD BEACH</u>
14. FATHER'S NAME First <u>Harry W.</u> Middle <u>Simon</u> Last <u>Simon</u>			15. MOTHER'S MAIDEN NAME First <u>Myrie</u> Middle <u>Phipps</u> Last <u>Phipps</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <u>162-09-8090</u>			17. INFORMANT <u>Anna P. Simon</u> ADDRESS <u>121 Lake Haven Place Dunedin, Fla.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHRONIC CORONARY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERAL YEARS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>176 HOURS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <u>NONE</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Henry V. Davis</u>		EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>		M.D.		22b. DATE SIGNED <u>6/11/69</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county) <u>CHESAPEAKE CITY MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>19 June 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City or Town) <u>Upper Darby Twp</u>		County <u>Del.</u> State <u>Pa.</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulais, Greenboro, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 16 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>			

08380

08380

10-10-10

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10-10-10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08284

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08277

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR M					
LESLIE			KENNETH			SPARKS			19			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR A.M.			
male	white	Sept. 18, 1950	18 YRS.					June 18, 1969			12:50 A.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Virginia			U.S.A.						Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Union Hospital			Student			--					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Virginia			Giles			Narrows						Narrows, Virginia		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last											
Roscoe Sparks			Josephine Conley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS								
No						Newberry Funeral Home, Bland, Va.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries														
8/21 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR MIN. 9:45 P.M. 6/17/69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in car - which was struck on right side by two trucks						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street				21f. LOCATION Street or R.F.D. No. City or Town County State Rte. 40 & Rte 7 at Del. Ave., Cecil, Maryland						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 6/18/69						
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										
				ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 6/21/69		23c. NAME OF CEMETERY OR CREMATORY Bradley Cemetery				23d. LOCATION (City or Town) (County) (State) Lindside, W. Va.				
24. FUNERAL DIRECTOR <i>Harold E. Hicks</i>				ADDRESS Hicks Home for Funerals, Elkton, Md.				25a. REC'D BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08285

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08278

1. DECEASED-NAME (Type or print) First Middle Last Mary S. Spratt			2a. DATE OF DEATH 6 Month 1 Day 69 Year			2b. HOUR 10:30 P.M.			
3. SEX F.		4. RACE W.		5. DATE OF BIRTH 5/9/98		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hosp. & Care Co.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Ind.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #3, Box 100A	
14. FATHER'S NAME First Middle Last Robert Smith			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth McDowell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 219-28-7768		17. INFORMANT Nep. Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of myocardium 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 min. 7-10 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Divides mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/1, 1969, to 6/1, 1969, that (I) (we) last saw the deceased alive on 6/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edgar E. Folkitt, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/2/69	
22d. PHYSICIAN'S NAME (Type) Edgar E. Folkitt, M.D.				22e. ADDRESS Union Hosp., Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Rosebank Cemetery		23d. LOCATION (City or Town) (County) (State) Calvert, Md.			
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.				25a. FILED BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08279

1. DECEASED-NAME (Type or print) ARTHUR F. STANLEY JR.			2a. DATE OF DEATH Month JUNE Day 18 Year 1969			2b. HOUR 2:00 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 3, 1919		6. AGE (In years lost birthday) 50	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL	
10. CITY OR TOWN OF DEATH LOCUST POINT		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RD # 2		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NEWSPAPER SALES		12b. KIND OF BUSINESS OR INDUSTRY SALES	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY CECIL		13c. CITY OR TOWN LOCUST POINT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RD # 2 Box 290		14. FATHER'S NAME First ARTHUR F. Middle STANLEY Last SR		15. MOTHER'S MAIDEN NAME First HELEN Middle NEWKIRK Last 		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b. SOCIAL SECURITY NO. 218-32-1947		17. INFORMANT CHRISTINE P. STANLEY		Address RD # 2 ELKTON Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA - 1621 DUE TO, OR AS A CONSEQUENCE OF (b) (Probably From Lung) DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JAN , 19 69 , to Present , 19 , that (I) (we) last saw the deceased alive on 14 JUNE , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Gray M.D.				DEGREE MD.		22c. DATE SIGNED 20 JUNE 1969	
22d. PHYSICIAN'S NAME (Type) Robert L. Gray				22e. ADDRESS 123 W. HIGH ST ELKTON Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JUNE 21, 1969		23c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY		23d. LOCATION (City or Town) (County) (State) ELKTON CECIL MD.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				25a. REC'D BY/REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE John J. Jones	

08288

OFFICE OF THE ATTORNEY GENERAL, STATE OF NEW YORK

CERTIFICATE OF DEATH

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ARTHYR E. JONES, JR.
Male
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Place of Death [illegible]
Date of Death [illegible]
Signature of Physician [illegible]
Signature of Registrar [illegible]

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "BORN" and "DIED" are faintly visible.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08287

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08280

1. DECEASED-NAME (Type or Print) MARY EMMA THOMAS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 6 30 1969			2b. HOUR 12:15 PM								
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 11, 1893		6. AGE (In years last birthday) 76 YRS.		7c. DATE PRONOUNCED DEAD 6 30 1969		2d. HOUR 12:27 PM				
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL								
10. CITY OR TOWN OF DEATH ELKTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY CECIL			13c. CITY OR TOWN CECIL CITY			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last ANDREW JACKSON MEADOWS						15. MOTHER'S MAIDEN NAME First Middle Last MARY ETTA BROYLES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS MRS AUDREY WOOD-PRINCETON, W. VA.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1 - Diabetes mellitus 2 - Fracture Left Hip														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Tillman D Johnson M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) Tillman D Johnson M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
						ADDRESS (Street, city, town, or county) Elkton, Cecil								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE JULY 3, 1969			23c. NAME OF CEMETERY OR CREMATORY NEW ZION CEM			23d. LOCATION (City or Town) (County) (State) ELGOOD - MERCER, W. VA.					
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME						25a. REC'D BY REGISTRAR JUL 3 1969			25b. REGISTRAR'S SIGNATURE William J. Judge					

08280

RECEIVED

72520



Handwritten text, possibly a date or signature, located below the circular stamp.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										08281	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Harry C. Tuwaddell						Month 6 Day 29 Year 1969			1230 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years less birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
Male	White	Nov. 16, 1879		89 YRS.	MONTHS DAYS		HOURS MIN.		Month 6 Day 29 Year 1969		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.	
Penna		U.S.A.		WIDOWED		DIVORCED		Cecil			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			Retired Farmer			Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Penna			Del. Co.			Boothwyn			YES X NO		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
William Tuwaddell			Mary Webster			385 Faulk Road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			182-01-5637			Mrs. Lillie Z. Tuwaddell, Boothwyn, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease										years	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES NO X			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
CAUSE OF DEATH				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK NOT WHILE AT WORK											
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
Tillman D. Johnson M.D.								6-29-69			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)			
Tillman D. Johnson M.D.				X							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		July 2, 1969		Silvann Cemetery				Bethel Twp. Del Penna.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
PIPPIN FUNERAL HOME, 1100 N. 2nd St, Elkton, Md.				JUL 7 1969				Charles Judge			

05370

STATE OF
NEW YORK



IN SENATE,
January 1, 1903.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08289

CERTIFICATE OF DEATH

08282

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 1305 Blossom Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie		First Middle Last M. Walker		4. DATE OF DEATH June 25, 1969		Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH April 19, 1883	
9. AGE (In years lost birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Catasaugua, Penna.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Oscar Fertig				14. MOTHER'S MAIDEN NAME Nora no info.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Peter Pfeiffer, Joppa, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Cerebral Vascular Accident Arteriosclerotic cardiovascular disease with congestive heart failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours Several yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Possible pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 16, 1969, to JUNE 25, 1969, that (I) (we) last saw the deceased alive on JUNE 25, 1969, and that death occurred at 9:30 A.M. from causes and on the date stated above							
22a. SIGNATURE S. Ralph Andrews, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-25-69			
22c. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR. M.D.		22d. ADDRESS 237 E. MAIN ST., ELKTON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-27-69		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION (City or Town) (County) (State) Wilmington New Castle, Del.	
24. FUNERAL DIRECTOR Pippin Funeral Home		ADDRESS Elkton, Md.		25a. REC'D BY REGISTRAR JUN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08389

CERTIFICATE OF DEATH

08389



Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	

4122
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08290

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08283

1. DECEASED-NAME (Type or print) HELEN J. WILLIAMS			2a. DATE OF DEATH 6 Month 8 Day 69 Year			2b. HOUR 3:00 PM				
3. SEX F		4. RACE W		5. DATE OF BIRTH 1-23-26		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL Md.				
10. CITY OR TOWN OF DEATH ELKTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY CECIL		13c. CITY OR TOWN CHESAPEAKE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER GEORGE	
14. FATHER'S NAME First Middle Last COLBERT BIGGS			15. MOTHER'S MAIDEN NAME First Middle Last KATIE BOOTS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 215-22-3489		17. INFORMANT Address GEORGE R. WILLIAMS CHESAPEAKE MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS SEVERAL YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JULY , 19 62 , to JUNE 8 , 19 69 , that (I) (we) last saw the deceased alive on JUNE 7 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Henry V. Davis					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/69			
22d. PHYSICIAN'S NAME (Type) HENRY V. DAVIS					22e. ADDRESS CHESAPEAKE CITY MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-11-69		23c. NAME OF CEMETERY OR CREMATORY BETHEL			23d. LOCATION (City or Town) (County) (State) CHESAPEAKE CITY, CECIL MD			
24. FUNERAL DIRECTOR R. T. FORD FUNERAL HOME CHESAPEAKE					ADDRESS CITY, MD		25a. REC'D BY REGISTRAR DATE JUN 11 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	

82520

STATE OF MARYLAND

82520



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